**SNAP-911 #**

# SPECIAL NEEDS ALERT PROGRAM ENROLLMENT FORM

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|---|---|---|
| Child's Name: | Name Child Responds To: | |
| Date of Birth: | | |
| Parent(s)/Guardian(s): | | |
| Home Phone: | Work Phone: | |
| Cell Phone: | Email: | |
| **MEDICAL INFORMATION** | | |
| Primary Medical Issue: | | |
| Other Medical Issues/Diagnoses: | | |
| Technology/Assisted devices: | | |
| Special Instructions: | | |
| | | |
| **HOME INFORMATION** | | |
| Street Address: | | |
| City: | Zip: | County: |
| Home Description: | | |
| Best Entrance for EMS Responders: | | |
| Child's room location: | | |
| Local Fire Department/Ambulance Service: | | |
| Caregiver's Name (if other than parent/guardian): | | |
| Caregiver's Phone: | | |
| **CHILD CARE/SCHOOL/DAY PROGRAM INFORMATION** | | |
| Child Care/School/Day Program: | | |
| Street Address: | | |
| City: | Zip: | County: |
| Local Fire Department/Ambulance Service: | | |

| **FOR INTERNAL USE ONLY** | | |
|---|---|---|
| Date of Application: | ☐ Technology | ☐ Medication |
| Date of Enrollment: | ☐ Non-Technology | ☐ Behavioral |
| Date of Home Visit: | Agency: | |

Easter Seals DISABILITY SERVICES

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

SNAP